(2) In the case of inpatient care, one year after the date of discharge; or

(3) In the case of retroactive approval for medical services/supplies, 180 days following beneficiary notification of authorization; or

(4) In the case of retroactive approval of CHAMPVA eligibility, 180 days following notification to the beneficiary of authorization for services occurring on or after the date of first eligibility.

(b) Requests for an exception to the claim filing deadline must be submitted, in writing, to the Center and include a complete explanation of the circumstances resulting in late filing along with all available supporting documentation. Each request for an exception to the claim filing deadline willbe reviewed individually and considered on its own merit. The Director, Health Administration Center, or his or her designee may grant exceptions to the requirements in paragraph (a) of this section if he or she determines that there was good cause for missing the filing deadline. For example, when dual coverage exists CHAMPVA payment, if any, cannot be determined until after the primary insurance carrier has adjudicated the claim. In such circumstances an exception may be granted provided that the delay on the part of the primary insurance carrier is not attributable to the beneficiary. Delays due to provider billing procedures do not constitute a valid basis for an exception.

(Authority: 38 U.S.C. 501, 1781)

[63 FR 48102, Sept. 9, 1998, as amended at 73 FR 65553, Nov. 4, 2008]

§ 17.276 Appeal/review process.

Notice of the initial determination regarding payment of CHAMPVA benefits will be provided to the beneficiary on a CHAMPVA Explanation of Benefits (EOB) form. The EOB form is generated by the CHAMPVA automated payment processing system. If a beneficiary disagrees with the determination concerning covered services or calculation of benefits, he or she may request reconsideration. Such requests must be submitted to the Center in writing within one year of the date of the initial determination. The request must state why the beneficiary believes the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the claimant without further consideration. After reviewing the claim and any relevant supporting documentation, a CHAMPVA benefits advisor will issue a written determination to the beneficiary that affirms, reverses or modifies the previous decision. If the beneficiary is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by the Director, Health Administration Center, or his or her designee. The Director, Health Administration Center, or his or her designee will review the claim, and any relevant supporting documentation, and issue a decision in writing that affirms, reverses or modifies the previous decision. The decision of the Director, Health Administration Center, or his or her designee with respect to benefit coverage and computation of benefits is final.

(Authority: 38 U.S.C. 501, 1781)

NOTE TO § 17.276: Denial of CHAMPVA benefits based on legal eligibility requirements may be appealed to the Board of Veterans' Appeals in accordance with 38 CFR part 20. Medical determinations are not appealable to the Board. 38 CFR 20.101.

[63 FR 48102, Sept. 9, 1998, as amended at 73 FR 65553, Nov. 4, 2008]

§ 17.277 Third-party liability/medical care cost recovery.

The Center will actively pursue third-party liability/medical care cost recovery in accordance with applicable law.

(Authority: 42 U.S.C. 2651; 38 U.S.C. 501, 1781)

[63 FR 48102, Sept. 9, 1998, as amended at 79 FR 54616, Sept. 12, 2014]

§ 17.278 Confidentiality of records.

Confidentiality of records will be maintained in accordance with 38 CFR 1.460 through 1.582.

(Authority: 5 U.S.C. 552, 552a; 38 U.S.C. 501, 1781, 5701, 7332)